

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 11 1957

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State File No.

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>6152</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>33 yrs</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>01 5949 Oakherst</u>				STREET ADDRESS (If rural, give location) <u>20570 5949 Oakherst</u>			
3. NAME OF DECEASED (Type or Print) <u>MATTHEW</u>		a. (First) <u>JOSEPH</u>		c. (Last) <u>BYRNES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 30, 1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Dec. 5, 1883</u>	
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Goods</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Patrick Byrnes</u>		13b. MOTHER'S MAIDEN NAME <u>Mary White</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-01-8030</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Isabelle McGrath</u> ADDRESS <u>5949 Oakherst</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>332x</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive Vascular disease</u>  INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  <u>unknown</u>  <u>6 years</u>				20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Oct. 1951</u> , to <u>June 30, 1957</u> , that I last saw the deceased alive on <u>June 12, 1957</u> , and that death occurred at <u>12:00 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Signature A. Flotte</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>1800. Kings Highway</u>		23c. DATE SIGNED <u>B 7-1-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 3, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUL 2-57</u>		REGISTRAR'S SIGNATURE <u>Charles Smith McCullen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kelly</u>		ADDRESS <u>7267 Natural Bridge</u>	

(Licensed Embalmer's Statement on Reverse Side)

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

*James A. Lamm*

Licensed Embalmer No. *414*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.